Motivational Interviewing A conversation of Empathy and Self-healing

Motivational interviewing (MI) is a patient-centered counseling approach used during a clinical visit. It can be briefly integrated into patient encounters and is designed to promote clarity and open communication while enhancing motivation to change behavior and clarify decisions among patients who are confused and not ready to change. MI is not just a series of techniques, but a spirit of collaboration and evoking of personal resources, while respecting the autonomy and personal freedom of choice.

Based on five principles, MI can assist patients in behavior change and enhance their resolve and personal-motivation. By focusing on the patient's concerns, perspectives and individual experience, as well as emphasizing personal choice in their healing process, MI offers strategies on a continuum. This may range from awareness of there not being a problem, to total commitment to utilize the steps in solving complex ones that are truly there. Techniques such as reflective listening, summarizing a conversation, and weighing costs and benefits, are utilized in MI, as communication styles supporting the patient's hopes, optimism, and self-efficacy.

The five principles of motivational interviewing are: (1) The practitioner uses empathy to engage, (2) develops discrepancy between where the patient is health wise and where they want to be, (3) avoids argumentation, while rolling with "resistance", (4) restrains the patient from taking a counter position to what you have said which would advantage their own status quo, and (5) supports the patient's belief in themselves being able to build self – efficacy.

This is an interviewing conversation rather than expert-directed and elicits careful questioning and listening on both sides. Information is shared reciprocally and is non-judgmental. A supportive, patient-centered atmosphere is pivotal to MI, where patients feel comfortable enough to explore their own reality and conflicts. Outlining a patient's goals (where they want to be) and their present situation (where they are) is an important part of developing the divergence from sickness to healing behavior. Keeping the tone motivational versus argumentative is a fundamental principle of MI and meets a patient's resistances with a different approach;

instead of confrontation or opposition, the practitioner keeps the conversation open, positive and on course. Instilling the belief that change is the choice of the patient rather than the practitioner centers the locus of control within the patient, rather than in an authoritarian way with the practitioner.

PATIENT/PROVIDER COMMUNICATION

Listening

In MI, listening involves checking out the perspective and ideas of the child and family. This makes MI a family-focused process. The provider replaces traditional interviewing that often placed the provider in the authority role. The MI goal is to refrain from communication styles of teaching that may diminish the child's/family's authority and voice. An example can be observed with Sarah, a pre-teen who had been diagnosed as having ADHD since 5 years of age and had recently not been taking her medication consistently. Associated with her resistance to medication had been an associated slipping of her grades with a possible school failure outcome ahead.

Hope in re-establishing her treatment adherence and the recovery of her borderline academic achievement appeared to be contingent on engaging and talking to Sarah in an open conversation. Gaining her opinion on the one hand, while listening to her express her beliefs and getting her to assert her preferences and goals on the other hand, was essential to such a conversation.

Prematurely lecturing and educating Sarah about the consequences of school failure i.e. only using school to hang out with friends, shirking viable problem solving, and finding good solutions, would only deepen her resistance, possibly engage increased guilt, self-blame, and quickly close the door to further conversation about the usefulness of medication and possibly weaken the relationship.

Research suggests that that 80% of the population often doesn't think there is a problem or are conflicted by their own ambivalence and contradictory behaviors while engaging in a contemplative pros and cons way. Likely, less than 20% of people at any one time might be willing to engage in "change talk" and be willing to consider a plan or even show readiness to be

educated with the necessary insights. Education strategies can have a reverse effect if done too early. By reducing motivation for change, rather than increasing the chances, people who are ambivalent can take a "self-righting stance". This means that where in the past they may have just argued, opposed the provider's position, and offered reasons not to change, the provider provides conversations assisting people in not talking themselves out of the change process prematurely.

The Language of Change Talk

The intention of MI is to move toward ways of "change talk" (eliciting the reasons for change). In this way the provider attempted to gain Sarah as a partner in the change process and create a conversation in which Sarah could come up with her own ideas and argue for reasons why she might benefit from resuming medication adherence. Note: The more that patient's hear themselves verbally defend their own position, the more committed they become to take steps leading to action.

The question was how to get Sarah to use more change talk? First, the provider waited for Sarah to hear herself and in this the provider had to be good listener themselves. By using the following kinds of talk in normal conversation Sarah was more able to recognize the patterns better by the feedback she gained. By listening to what she said, one could tell how Sarah reconsidered medication. If the provider had argued for medication and gotten into an argument with her, Sarah would have countered with a defense of keeping things the same. Sarah would have won the fight temporarily and such a normal resistance had to be considered.

The use of the following conversational cues may help in avoiding such 'dead end' verbal interactions. Desired are alternative responses of "I will take my..." or "I will try..." or "I will consider it," or "I might." To obtain such verbal responses it will be helpful to learn the six possible "ready-able and willing" themes using the **DARN-CASA** mnemonic:

- *D esire statements:* Using "I wish," "I want to," or "I would like" are examples of preferences. "Why might you want to do this?"
- A bility statements: Sound out strengths of one's position with "can" and "could." "What is possible for you?" "If you decided to take your medication, how would you do it?"

- *R eason statements:* May be added after language of ability connected with "because." For example, "...so my grades would improve and get people off my back." What are some benefits? (Why?) statements.
- *N eeds:* Needs verbs construe significance and importance. "I should get organized or get my work turned in." Use "must" and "have to." "How important is it to make this change?"
- C *ommitment* words include words that connote readiness with "I am going to," "I will," and "I intend to."
- *S teps toward action:* This promotes further along the change continuum and does something that moves Sarah in the direction of making it happen. Make a plan and now is the time for problem solving.
- A mbivalence: Weighing pros and cons and starts out resolving the barriers to free choice and making a decision is a major feature of motivational interviewing as a way to manage ambivalence around change. Early conflicts about pros and cons for each side of one's dilemma often lead to keeping bad habits and routines the same.

Such is often the case for keeping things the same in one's lifestyle and unhealthy behaviors. Sarah expressed costs and benefits related to stopping her medication. Asking her, "What is good about the way things are now?" may signal: "I don't have to go to the office to take a pill," "There is less hassle," and "I have fewer headaches." On the other hand, "The teachers are on my case," and "Parents are disapproving of my behavior and report card," and "I don't like the idea of a pill controlling me."

A key strategy is to provide a summary at the end of these junctures to highlight both sides of the dilemma, how one horn undermines the goals of the other. For example, "What do you make of this?" or "Where do you go from here?" After an empathic statement, do not prematurely start "problem solving" if the patient is still arguing and resisting you. Rather, "What would the first step be for you?" By going through this, Sarah is more likely to

carry out a plan if she can answer what, where, when, and how, she will do it.

If Sarah is not really ready, it will be not as threatening going back a step using conjecture and indefinite language such as "What might it take to make a decision for you?" or "Suppose you decide what might be some of the benefits?" or "Can you imagine a change how things could be different?" or "What would it be like for you to go from a 5 to a 7 on a 1-10 scale in terms of your confidence?" and then "What currently impossible thing, if it were possible, might change everything?"

GETTING STARTED: LEARNING MOTIVATIONAL INTERVIEWING AS A WAY OF BEING WITH YOUR PATIENTS

Beginning with your consultations that you will have today, the best teachers for learning this process will be your patients. Like Sara and her parents, their aim is wanting things to be better. They come to a provider to help them facilitate getting unstuck. They will bring those aspects of their sordid humanity that keeps them repeating the same things over and over or just denying that there is a problem.

Deciding on the balance for a provider in their communication style will influence their asking questions, how they will listen, and what advice they will give based on the way people naturally talk and help others. The communication styles may in part be a leading or directive approach, or a style of following the child or family's lead, or perhaps even more helpful, a preferred combined "guiding style" of reciprocal interactions.

Sara, as a preteen, likely would need a more soft but interesting engagement. By matching her style with active listening and asking questions gently, minimizes her cynicism and adjustment to authority. Regardless, shifting to a communication style at her level is a must while seeking engagement and showing interest in her wishes, needs and preferences. The provider must be mindful of both verbal and nonverbal expressions that may help keep the conversation open. Goals should be arrived at naturally. Let Sara help decide on the topics to be talked about. Give her a menu of the agenda promoting her choices while helping her build a stronger voice.

Be mindful of the "RULE's" of motivational interviewing standing for:

- Resist the righting reflex (arguing against your solutions that may be promoted too early for problem solving).
- Understand Sarah's motivations under previous discussion of change talk.
- Listen with empathy using basic reflective communication skills. **Foundations for Two-way Communication,** an added resource for this topic, can be found in the Appendix A.
- Empower Sara for optimistic and hopeful outcomes by using her resources to get what she wants.

Strategies and Techniques

A provider might consider using some of the following practical techniques:

- Readiness ruler. A one to ten scale for estimating the importance of topics or confidence in being able to carry them out (see previous discussion on ability and motivation talk as a part of what it would take to go from a 5 to a 7 or why is it not a 3 when 5 is reported.
- Agenda setting chart. Write a few of the self-selected topics to work on. For example, such priorities might include eating, exercise, leisure, stress or talking about medication and see if the individual is interested in consenting to one or two of these.
- Using a typical day. The client or patient can talk about how a normal day goes from start to finish relative to the topic at hand. For example, how taking medication fits into their day.
- Continue to explore costs and benefits with the good things and not-so-good things.
- Exchanging information and having a conversation with feedback sometimes including *bad news*. "What have you thought about this so far?" "Do you want to know more?"
 - o <u>Elicit</u>. Get patient's concerns and perspectives first. "What connection if any can you see between not taking medication and your behavior in grades, etc?"
 - o <u>Provide</u>. "Would you like to hear more about medication and how it works, including side-effects?"
 - Elicit. Assess person's interpretation of this new information.
 "What do you make of this?"
- Do not argue/ but roll with the *resistance*. Come up with more empathy statements, and offer reflections if they are needed.
 Resistance is considered more a relational problem; therefore you may

need to engage more. Diffuse it, redirect it, and reframe it. Promote an alternative perception. Give them choices and personal control. The issue to talk about is their decision. You may wish to review pros and cons again.

• Review change continuum. Rather than a discrete change, change is not so much a discrete event but may be considered on a line from precontemplation to maintenance. Consider different approaches for each stage. The earlier levels need to work more on motivation needs and reasons for change.

Pre-contemplation involves not even having a thought that there is a problem.

Contemplation. Only thinking about it and may be confused by the ambivalence.

Preparation. Thinking about it and taking some steps that may involve coming up with a plan. Strategies and interventions will be directed eliciting more confidence and ones ability to do this.

Action. Taking steps with initiation of solutions and problem solving. Here is when they need more education.

Maintenance. Adhere to a plan for an extended time. The idea is to prevent relapses and use more reinforcement and behavior management. A 1 to 10 scale may also be helpful.

Advice to change. After developing a relationship and hearing perspectives, the mnemonic "RAISE" may be helpful. This stands for

R elationship,

A dvice to change,

"I" statements(for example, "I will not pressure you.",

S upport autonomy in choices, and finally

E mpathy.

You may wish to get more information on the change process at the following link. It is an ABLE handout on ways to observe and measure what is different and has changed and how much progress has been made. It

fits with MI and speaks again to find ways to uncover what can't be readily seen http://health.utah.gov/able/PDF_forms/handouts/PerceivingChange.pdf

SUMMARY

Motivational interviewing is a person-centered, focused and goal directed process with ambivalence resolution (A style of communication for enhancing intrinsic motivation to change behavior or shift a new idea into steps toward action).

In the fashion of Carl Rogers, the practice of motivational interviewing builds upon clear and concise communication of the conditions for behavior change including accurate understanding (empathy), unconditional regard (warmth and acceptance), and genuineness (congruence between parties).

The spirit of motivational interviewing conveys partnership and companionship, where a relationship with a helper can evoke and stir up one's own internal resources, intrinsic values and goals in the service of change while capturing a person's own autonomy and freedom of choice.

Major principles of MI practice bring forth active listening, with expressions of empathy, and the development of discrepancy using examples of a patient's own motivations, rolling with possible resistances by resisting "self-righting reflexes" while supporting self-efficacy with empowerment of hope and optimism. Ambivalence or lack of resolve for decision making involves clarifying change in resistance with awareness of both sides of the same coin.

Assess using a 1-to-10 scale on what is most significant, as well as one's own confidence and priorities, determining motivations for being ready, willing, and able (less a factor of personality and more related to interpersonal interaction). Health care providers sometimes jump in too quickly to problem-solve (trying to fix something when it is perceived to be broken), when what is really required is "getting ready," assessing what is important, whether the patient thinks they can do it, and assessing where the resources will come from within. Such is the stuff and content of motivational interviewing.

Appendix A

FOUNDATIONS FOR TWO-WAY COMMUNICATION

You are so wise to have clicked on this "hidden agenda" because its importance represents the foundation and scaffolding and is a "major agenda" for motivational interviewing.

Much of what individuals do as providers in healthcare is to exchange information: both getting information and giving back or informing. Conversations involve not just dealing with facts but their interpretation through the use of the skillful listening, careful questioning and well-timed sensitive interventions. The ways providers can be sensitive to a balanced two-way, give and take measure of sharing together the way we talk will impact not only a satisfied and cooperative patients, but with improved developmental, social-emotional and healthy outcomes.

For example, "history taking" associated with a fuller discussion with elaboration of particular details where needed, asking of questions by the patient, giving information after asking permission, and emotional support while promoting assertion, all conversationally, is associated with improved physical symptoms, psychological distress, improved health (blood pressure and blood sugars) and many other physical outcome measures.

A conversation where hearing oneself (and "seeing" at the same time with time for reflection), is a mindful process and requires silent periods at junctures during talking. Also having a sense of hearing your own statements of one's reasons for doing something different promotes mindfulness of the discrepancy between one's desires, preferences, and present actions.

The greater the discrepancy promoted, the greater perceived importance of change and certainty one acquires. The mnemonic "OARS" cues us to better inform, ask and listen with greater awareness of sensitivity and empathy. Willingness to understand the experience of our patients' thoughts, feelings, and concerns leads to improved rapport and is featured by:

Open-ended questions which invite storytelling.

- Closed questions close the conversation and make for a passivity and disconnection.
- Affirmations Statements of acknowledgment and appreciation of a person's efforts.
- Active listening Reflective listening is taking a guess at what is said and echoing it back in a short statement. These are efforts to keep the conversation going, to get another perspective and ultimately insight. Resistance as well as positive statements (change talk) deserves feedback twice, once from the patient themselves and once from the helper. Resistance can be diffused.
- Simply repeating back may not be the best kind of reflection especially if it sounds corny and out of place whereas,
- Rephrasing and altering what is said in a different way is a great gift.
 For example,

Patient "I want to take my medication because it helps my mind stay focused."

Health Provider "You realize taking your medication keeps your mind quietly alert."

- Empathic understanding Reflects acknowledgment. For example, Patient "How can you even know what it is like for me?" Health Provider "It is hard to imagine how I could comprehend what you go through."
- Reframing another view to think differently about it. For example, Patient "My work is so sloppy I feel like giving up." Health provider "You keep going like the Ever-ready-Rabbit!"
- Reflect feelings and emotional tones For example,

Patient "It seems like I cannot pass that class. My friends must think I am dumb."

Health Provider "It has really been hard for you without your medication and you are afraid of losing your friends."

Amplified reflection - Repeating back an exaggerated response. For example,

Patient "The way I act is not all that bad."

Health Provider "You are not concerned about your behavior because you just have not broken anything." (Needs to be genuine, not sarcastic.)

Double-sided reflection - Bring forth both sides of a dilemma. Patient "Medication helps my thinking but makes me feel I'm not in control of my destiny." Health Provider "On the one hand, it helps you, but on the other hand you do not like it's taking over your free agency to make decisions for you."

• A longer summary - This is an opportunity to reflect back a longer piece listing the pros and cons highlighting both sides of the argument and the uncertainty. This is very useful at junctions in the interview to bring together and organize diverse pieces of information.

You can go to

http://health.utah.gov/able/forprofessionals/ourpractices/op_part1/op_part1.html for more information. Understanding shared conversations involves listening and creating a flow of heartfelt talk. One can find ways that ABLE has brought together basic communication skills associated with motivational, ethnographic and multicultural interviewing. Titled "Sharing Heart-Felt Talk"

Also, a Part 2 compared to Part 1 above offers advanced ideas of sharing mindful talk using a continuum of developmental risks and protective factors in transactional ways (two-way interactions) in order to generate stories leading to new multicultural identities This may be found at http://health.utah.gov/able/forprofessionals/ourpractices/op_part2/op_part2.html

and is titled "Sharing Mindful Talk."

References and Resources

The paper is based on these following sources, primarily from using "Motivational Interviewing to Promote Behavior Change and Enhance Health" by Belinda Borrelli. The citation is on medscape.com/viewprogram/5757_pnt. This will require a short-term registration to Medscape if you want to read this well written MI piece.

- Motivational Interviewing in Health Care: Helping Patients Change Behaviors – This is an excellent motivational interviewing introduction. It is easy and inspired reading for the work we all do by Stephen Rollnick and William Miller, Guilford Press 2008.
- Motivational Interviewing by W. Miller and S. Rollnick, Second Edition, Guilford Press 2002
- <u>www.motivationalinterviewing.org</u> (a very comprehensive offering for the basis of using this practice to help people make decisions about their behavioral changes).
- www.casaa.unm.edu/mi.html (promotes comprehensiveness to using MI for addictions and substance abuse featuring a general background).
- "Doc com," which is a 40 multimedia and rich interactive online role modeling of communication skills. Registration is needed for a 15-day free trial and is available at www.aachonline.org/doccom. This is an excellent resource for persons who work in the health care field who want to benefit from a didactic resource for interacting, communicating, and listening to their patients.